Triage Note

[redacted]

* Final Report *

Result date: 28 October 2012 9:55 EDT
Result status: Auth (Verified)

* Final Report *

ED Triage Entered On: 10/28/2012 10:00 EDT
Performed On: 10/28/2012 9:55 EDT by [redacted]

Assessment I
Chief Complaint : pt with treach, and hemodialysis there is no therapist where he resides. there is no care for his treach, and he has green drainage. pt was not on 02 on ems arrival. pt had confusion and hallucinations.
IV Field Start : No
Affect/Behavior : Calm, Cooperative
Pain Scale Type : 0-10 Pain scale
Primary Pain Intensity : 0
Allergies Reviewed : Yes
Temperature Tympanic : 99.1DegF(Converted to: 37.3DegC)
Peripheral Pulse Rate : 105bpm (HI)
Respiratory Rate : 24br/min (HI)
Systolic Blood Pressure : 126mmHg
Diastolic Blood Pressure : 68mmHg
SpO2 : 92% (LOW)
Oxygen Flow Rate : 6L/min
Dosing Weight : 90kg(Converted to: 198lb 7oz, 198.416lb)
(R) Patient Weight : Stated
Height : 67Inch(Converted to: 5ft 7Inch, 170.18cm, 5.58ft)
[redacted] 10/28/2012 9:55 EDT

Assessment II
Pregnancy Status : N/A
Fall Risk Order Detail : No
Languages : English
[redacted] 10/28/2012 9:55 EDT

Dx Control/PMH
Triage Reason for Visit : Yes
[redacted] 10/28/2012 9:55 EDT
(As Of: 10/28/2012 10:00:13 EDT)

Problems(Active)
Tracheostomy tube [redacted] owerChart ; *Last Updated:* 09/24/2012 8:10 EDT ; *Life Cycle Date:* 09/24/2012 ; *Life Cycle Status:* Active ; *Vocabulary:* SNOMED CT

Diagnoses(Active)
Altered mental status *Date:* 10/28/2012 ; *Diagnosis Type:* Reason For Visit ;

[redacted]

Triage Note

[redacted]

* Final Report *

Confirmation: Complaint of ; *Clinical Dx:* Altered mental status ; *Classification:* Present On Admission ; *Clinical Service:* Emergency medicine ; *Code:* SNOMED CT ; *Probability:* 0 ; *Diagnosis Code:* 2576783013

ESI
Requires immediate life-saving interventions? : No
Is this a high risk situation?
Consider AVPU score. : No
How many different resources are needed? : Many
ESI vital sign alert : No
ESI recommended level : 3
ESI clinical agreement : Yes

[redacted]

DCP GENERIC CODE
Tracking Specialty : Main ED
Tracking Acuity : 3
Tracking Group : ED Tracking Group

[redacted]

Allergy

(As Of: 10/28/2012 10:00:13 EDT)

Allergies (Active)
NKA

[redacted]

[redacted]

ED Note-Physician

[redacted]

Result date: 28 October 2012 10:57 EDT
Result status: Auth (Verified)

medical

Patient: [redacted]
Age: 5[redacted]
Author: [redacted]
Attachments: None

Basic Information
Time seen: Date & time 10/28/2012 10:57:00.
History source: Patient
Arrival mode: Ambulance.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint.
10/28/2012 9:55 EDT Chief Complaint pt with treach, and hemodialysis there is no therapist where he resides. there is no care for his treach, and he has green drainage. pt was not on 02 on ems arrival. pt had confusion and hallucinations.

History of Present Illness
The patient presents for re-evaluation of "sent to hospital because I had a argument with a nurse". No new complaints. usually with nausea after HD last HD yesterday. Symptoms since visit: today. Therapy today: none. Associated symptoms: none.

Review of Systems
Constitutional symptoms: Negative except as documented in HPI.
Skin symptoms: Old would pressure ulcers.
Respiratory symptoms: Negative except as documented in HPI and on vent. Has same chronic trach discharge. no change.

Cardiovascular symptoms: Negative except as documented in HPI.
Gastrointestinal symptoms: Negative except as documented in HPI.
Genitourinary symptoms: Negative except as documented in HPI.
Neurologic symptoms: Negative except as documented in HPI.

Health Status
Allergies: .
Allergic Reactions (All)
NKA
Medications: (Selected).
Prescriptions
Ordered
Ambien 5 mg oral tablet: 5 mg = 1 tab, Oral, Tablet, qHS, PRN insomnia, # 10 tab, 0 Refill(s), other reason (Rx)
Protonix 40 mg oral delayed release tablet: 40 mg = 1 tab, Oral, Tablet EC, qDay, # 30 tab, 0 Refill(s), other reason (Rx)
Vitamin B Complex with C and Folic Acid oral tablet: 1 tab, Oral, Tablet, qDay, # 30 tab, Refill(s) 0
albuterol 0.63 mg/3 mL (0.021%) inhalation solution: 0.63 mg, Nebulized, TID, # 75 mL, 0 Refill(s), other reason (Rx)
clotrimazole 1% topical cream: 1 app, Topical, Cream, BID, # 15 gm, Refill(s) 0, other reason (Rx)
codeine-promethazine 10 mg-6.25 mg/5 ml oral syrup: 5 mL, Oral, Syrup, q6hr, PRN cough, # 60 mL, Refill(s) 0, other reason (Rx)
collagenase 250 units/g topical ointment: 1 app, Topical, Ointment, qDay, 1 gm
duloxetine 60 mg oral delayed release capsule: 60 mg = 1 cap, Oral, qDay, # 30 cap, 0 Refill(s)
folic acid 1 mg oral tablet: 1 mg = 1 tab, Oral, Tablet, qDay, # 30 tab, 0 Refill(s)
heparin 5000 units/mL injectable solution: See Instructions, Heparin Sub cutaneous injections 5000 u every 8 hrs for DVT prophylaxis, # 1 app, 0 Refill(s), other reason (Rx)
lisinopril 40 mg oral tablet: 40 mg = 1 tab, Oral, Tablet, qDay, # 30 tab, 0 Refill(s)
metoprolol tartrate 25 mg oral tablet: 37.5 mg = 1.5 tab, Oral, Tablet, q12hr, # 90 tab, 0 Refill(s), other reason (Rx)

midodrine 5 mg oral tablet: 10 mg = 2 tab, Oral, Tablet, One Time Unscheduled, PRN other- see order comments, # 60 tab, 0 Refill(s), other reason (Rx)
morphine 15 mg oral tablet: 15 mg = 1 tab, Oral, Tablet, q4hr, PRN pain, # 24 tab, 0 Refill(s), other reason (Rx)
nystatin 100,000 units/g topical powder: 1 app, Topical, Powder, Ad Lib, 1 gm, rash
sevelamer carbonate 2.4 g oral powder for reconstitution: = 1 Pack, Oral, Injection, TID, # 90 Pack, 0 Refill(s), other reason (Rx)
tamsulosin 0.4 mg oral capsule: 0.4 mg = 1 cap, Oral, Capsule, qDay, # 30 cap, 0 Refill(s)

Documented Medications
Ordered
Cepacol Sore Throat mucous membrane lozenge: Oral, Lozenge, q2hr, PRN sore throat, Refill(s) 0
ferrous sulfate 300 mg/5 mL (60 mg elemental iron) oral liquid: 300 mg = 5 mL, OG, Liq, TID, 0 Refill(s)

Immunizations: Include Immunizations.

Previous
influenza virus vaccine, inactivated: Ad hoc dose (influInj) 10/28/2010 EDT, Ad hoc dose (influInj) 10/08/2011 EDT, Ad hoc dose (influenza vaccine, adult) 10/09/2012 EDT.
pneumococcal 13-valent vaccine: Ad hoc dose () 03/20/2012 EDT.
pneumococcal 23-valent vaccine: Ad hoc dose (Not Given) 01/20/2010 EST, Ad hoc dose () 06/30/2012 EDT.

Future
No future immunizations have been selected or recorded.

Past Medical/ Family/ Social History

Problem list: Include problem list (past medical history).

All Problems
Tracheostomy tube / 207832018 / Confirmed
Inactive: Acute pancreatitis / 303630010
Inactive: Alcohol abuse / 25750014
Inactive: Alcohol withdrawal syndrome / 294674018
Inactive: Bleeding precautions / 50851019
Inactive: Cardiac arrest / 2472090018
Inactive: Cataracts / 2839686017
Inactive: Cholecystectomy / 64698015
Inactive: Clostridium difficile infection / 286580015
Inactive: Colitis / 106758018
Inactive: Contusion of hip / 74751019
Inactive: Depression / 380529010
Inactive: Depression / 486184015
Inactive: Drug abuse / 44243014
Inactive: EtOH - Alcohol / 2579708017
Inactive: Gastritis / 7841019
Inactive: HTN - Hypertension / 2164904016
Inactive: Hypercholesterolemia / 23283015
Inactive: MACULAR DEGENERATION (SENILE) OF RETINA, UNSPECIFIED / 362.50
Inactive: Respiratory arrest / 144786014
Inactive: Tarsal tunnel decompression / 494816014
Inactive: Tonsillectomy / 268484012
Resolved: Suicidal ideation / V62.84

Surgical history: .
Tarsal tunnel (SNOMED CT 32945011) in 2008 at 51 Years.
History of knee surgery (SNOMED CT 2692296016) in 1982 at 25 Years
Cholecystectomy (SNOMED CT 64698015)
History of tonsillectomy (SNOMED CT 2790280011).
Comments:
10/06/2011 14:50 - [redacted]
1985 does know specific dates

Family history: .
No family history items have been selected or recorded.

Social history: Alcohol use: Denies, Tobacco use: Denies, Drug use: Denies, Family/social situation: Nursing home resident.

Physical Examination

Vital Signs

Vital Signs.

10/28/2012 9:55 EDT Temperature Tympanic 99.1 DegF
Peripheral Pulse Rate 105 bpm HI
Respiratory Rate 24 br/min HI
Systolic Blood Pressure 126 mmHg
Diastolic Blood Pressure 68 mmHg
SpO2 92 % LOW

Measurements.

10/28/2012 10:35 EDT Height 67 inch
Patient Weight Stated
BSA 2.06
Body Mass Index 31 m2
Dosing Weight 90 kg

10/28/2012 9:55 EDT Height 67 inch
Patient Weight Stated
Dosing Weight 90 kg

Basic Oxygen Information.

10/28/2012 10:35 EDT Height 67 inch
Patient Weight Stated
BSA 2.06
Body Mass Index 31 m2
Dosing Weight 90 kg
Primary Pain Intensity 0
Pain Scale Type 0-10 Pain scale
Cardiovascular Assessment PF Assessment norms met
Cardiovascular Assessment Norms Heart rhythm regular, Nail beds are pink, No edema
Respiratory Assessment PF Exceptions noted
Respirations Unlabored, Other: trach
Respiratory Pattern Regular
Respiratory Pattern Description Regular
Cough Occasional
GI Assessment PF Assessment norms met
Gastrointestinal Assessment Norms Abdomen soft, nontender, nondistended, Bowel sounds present in all 4 quadrants, If present, stools are soft, formed, brown and within last 3
Integumentary Assessment PF Exceptions noted
Skin Abnormality Present Yes
Incision/Wound, Ulcer, Skin Tear Present Yes
Surgical drains/tubes present No
Skin Abnormality/Location Grid Skin Abnormality/Location Grid
I/W Present on Admission-Site A Yes
Site A Healed No
Incision/Wound Type-Site A Traumatic wound
Incision/Wound Location-Site A Other: knees
Feels Safe at Home? Yes
Depression Medical History Yes
Medical Devices None

Reg Cigarette Smoking Last 365 Days No
Skin Breakdown Risk Triage Yes
Tobacco Use > 1 year ago
ED Assessment Adult Form ED Assessment Adult Form
ED Assessment - Nurse ED Assessment Adult
10/28/2012 9:55 EDT Reg STK Adm Elective Carotid Intervent No
Reg VTE Surgical Patient No
Reg VTE ICU Surgical Patient No
10/28/2012 9:55 EDT Reg SC Clinical Trial No
Reg STK Clinical Trial No
Reg VTE Relevant Clinical Trial No
Reg VTE Present on Arrival No
10/28/2012 9:55 EDT Reg AMI Relevant Clinical Trial vA No
Reg HF Relevant Clinical Trial No
Reg PN Clinical Trial vA No
10/28/2012 9:55 EDT Chief Complaint pt with treach, and hemodialysis there is no therapist where he resides. there is no care for his treach, and he has green drainage. pt was not on 02 on ems arrival. pt had confusion and hallucinations.
Height 67 inch
Patient Weight Stated
Dosing Weight 90 kg
Temperature Tympanic 99.1 DegF
Peripheral Pulse Rate 105 bpm HI
Respiratory Rate 24 br/min HI
Systolic Blood Pressure 126 mmHg
Diastolic Blood Pressure 68 mmHg
SpO2 92 % LOW
Primary Pain Intensity 0
Pain Scale Type 0-10 Pain scale
Oxygen Flow Rate 6 L/min
Pregnancy Status N/A
Affect/Behavior Calm, Cooperative
Languages English
IV Field Start No
ESI life-saving interventions needed No
ESI high risk situation/AVPU score eval No
ESI resources needed Many
ESI vital sign alert No
ESI recommended level 3
ESI clinical agreement Yes
Tracking Group ED Tracking Group
Tracking Acuity 3
Allergies Reviewed Yes
Fall Risk Order Detail No
ED Triage Form ED Triage Form
Triage Note ED Triage

General: No acute distress.
Skin: Dried healing lesions on bilateral knees, guaze in place, dried blood .
Head: Normocephalic.
Neck: Supple and Tach collar in place.
Eye: Pupils are equal, round and reactive to light and extraocular movements are intact.

Ears, nose, mouth and throat: Oral mucosa moist.
Respiratory: Lungs are clear to auscultation.
Gastrointestinal: Soft, Nontender and Non distended.
Genitourinary
Neurological: No focal neurological deficit observed, normal motor observed and normal speech observed.

Medical Decision Making
Differential Diagnosis:hallucinations, Mild hypokalemia, Dehydration, PNA.
Chest X-Ray: Include Rad interp(flowsheet) : Diagnostic Radiology.
10/28/2012 12:22 EDT XR Chest Portable 1 View REPORT

Reexamination/ Reevaluation
Time: 10/28/2012 12:19:00 .
Vital signs
results included from flowsheet : Vital Signs
Pain status: pain level 0 out of 10.
Notes. Nurse reporst that patient seems consued, 'asking when Linda is coming, " "Can you pick up the needle off the floor because the little girl is coming" .

Impression and Plan
Hypokalemia, Mild, Visual hallucinations- improved
Plan
Condition: Improved, Stable.
Disposition: Patient care transitioned to: Time: 10/28/2012 17:00:00. [redacted] On return to NH once poatssium and after seen by BH..
Follow up with: [redacted] Within 1-2 days See the NH Doctor tomorrow or your primary care to review your medications.
Counseled: Patient.

INTER-AGENCY PATIENT REFERRAL REPORT

W 10 (Rev 7/93)

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES Health Services

IDENTIFICATION DATA

[redacted] | SEX M | [redacted] | ADMISSION DATE 10-11-12 | DISCHARGE DATE 10-28-12

[redacted] | HOME PHONE NO | MARITAL STATUS | RELIGION

RESPONSIBLE PERSON IN AGENCY (Name and Address) | TELEPHONE NO

[redacted] | ONT [redacted] | NF [redacted] | TELEPHONE NO

[redacted] (Physician or Clinic) | TELEPHONE NO | DATE OF NEXT APPOINTMENT

2 [redacted] | OTHER

PATIENT CARE INFORMATION AND ORDERS

Dx: Rhabdomyolysis Leading to Renal failure - ESRD
C-Diff - Tracheostomy - G tube - Mastoiditis - Sepsis
Depression

Diet: Renal diet + Jevity 1.0 240cc bolus @ 10pm

*May have meds PO or via G-tube
Bolus ē 150cc H2O Every 8hrs to keep G-tube patent

Dialysis @ [redacted] M-Th-Tues-Thurs-Sat

Tx to [redacted] ē Calcium Alg -

Meds: (cont)
Lisinopril 40mgm PO @ 9A
MultiVit ē B C & folic Acid @ 9A
Pantoprazole 40mgm PO @ 9A
Metoprolol 37.5mgm PO Every 12hrs
Morphine 15mgm Every 4hrs PRN

Pneumo 10/26/12
Flu Vac 10/9/12

TM ↑ Confusion x 2 days
Hallucinating
O2 Sat 95%
98.2 114-22 186/104
8AM 112-22 182/100
O2 Sat 94%

MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN	MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN
1 Heparin 5000 units @ 8hrs SQ			2 Albuterol Inh Tx	3x day	
3 Sevelamer Carbonate 2.4gm Powder	3x day		4		
5 Lamotrigine 0.4mgm @ bedtime			6 Ca Acetate 667mgm PO @ 9A		
7 Folic Acid 1mgm @ 9A			8 Lexapro 10mgm PO @ 9A		

ALLERGIES: NKA

DIAGNOSIS GIVEN | EXPLAINED TO ☐ Patient ☐ Family

PROGNOSIS | EXPLAINED TO ☐ Patient ☐ Family

THERAPEUTIC GOALS: "Full Code"

PATIENT SERV START DATE

SERVICES REQUESTED ☐ Nursing ☐ Occ therapy ☐ Speech therapy ☐ Physical therapy ☐ H H aide ☐ Social work ☐ Other (specify)

IS TREATMENT FOR CONDITION FOR WHICH PATIENT WAS HOSPITALIZED (If NO explain) ☐ Yes ☐ No

PATIENT ESSENTIALLY HOMEBOUND ☐ Yes ☐ No

I HEREBY CERTIFY THAT THE ABOVE SERVICES SHOULD BE PROVIDED BY ☐ Acute Hosp ☐ Chronic Hosp ☐ NF ☐ Home Health Agy ☐ Rehab Center [redacted] DATE SIGNED 10-28-12

ONE

[redacted]

ED E
Physician, ED

10/28/2012

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

Current Psych Treatment ☒ NO ☐ YES Provider _____

Last Appointment _____ Next Appointment _____ Contacted ☐ YES ☐ NO
If no, explain _____

Source of information ☒ Self ☐ Family ☒ Medical Record ☐ Other _____

HISTORY OF PRESENT ILLNESS (HPI). *(describe current status, stressors and events leading up to this assessment)*
Chief Complaint (Patient's own words) "I'm on dialysis for my kidneys."

Context Pt is a 55y.o. D/C/M BIBA from [redacted] nursing facility 2° ↑ Blood pressure of 182/100 and HR of 100 and it not decreasing after given Lisinopril. Staff member [redacted] also reports pt has had ↑ incontinence/VH. Pt reports he has had ↓ appetite, ↓ sleep since a motorcycle accident 8/2012 that left him with a tracheostomy tube and possible paralysis of arms and legs. Pt admits ↑ depression due to inability to care for himself and needing to live at [redacted] until able to care for himself again. Pt denies SI, HI, AH, but does report + VH since he began taking Ambien for sleep. Pt says he will see people from his past, and each episode lasts ≈ 10 seconds until he looks back and realizes they are not there. Pt says these VH have been ↑ past week, but have been occurring for the 1st time in his life about 3 weeks ago when he started Ambien. Pt reports this scares him. Pt has hx 2 SI attempts through overdose in 2010 and 2011. Pt denies SI current and requesting to go back to ECF. Pt has hx alcohol dependence but denies drinking since 8/2012. Pt currently in End stage

☐ Family / Significant other report (see below) ☐ No Family / Others available to report
☐ Patient refuses to allow contact with family / others

Renal failure and on dialysis.

History of ☒ Med Noncompliance ☐ Treatment Noncompliance Describe _____
Rx OD 2010/2011

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 6:45pm

[redacted]
ED
Physician, ED

10/28/2012

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

MEDICAL HISTORY
Medication or other Allergies No Known Allergies

Primary Care Doctor [redacted]

Current Medical Problems ☐ NO or give details Tracheostomy tube, hyperkalemia, unable to move arms and legs 2° motorcycle accident, Gastritis, HTN, hyperlipidemia, Vitamin B12 deficiency, hypothermia, ESRF

Pregnant ☐ NO ☐ Not Tested ☒ Not applicable ☐ YES OBGYN _____

Are you currently experiencing any pain? ☐ YES ☒ NO ☐ Acute ☐ Chronic

Have you had pain in the last several weeks? ☐ YES ☒ NO

If yes, *discuss with MD and document discussion and name of MD* _____

Past Medical Problems ☐ NO or give details hx thrush, see above, hx motorcycle accident (2012)

Surgeries Tarsal tunnel 2008, Knee surgery 1982, Cholecystectomy, tonsillectomy

Psychiatric Medications	Dosage	Frequency	Last Taken	Prescribing MD
See attached				
Other Medications	**Dosage**	**Frequency**	**Last Taken**	**Prescribing MD**

Previous Psychiatric Medications ☐ NO or unknown ~ Cymbalta, Lexapro, Remeron

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 5:40pm

[redacted] 10/28/2012

ED/ E
Physician, ED

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

Past Psychiatric Treatment

Inpatient or Outpatient	Where	Reason	Dates of Treatment
IP	PS	SI	12/8/11 to 12/15/11
IP	PS	Depression/ETOH	2004, 2001
OP	[redacted]	" "	

Substance Use/Addictions

Substance	Date of Last Use	Age of onset	Duration (Y/M)	Intensity	Patterns of Use	Consequences of Use	Use by Family Members
Alcohol	PRIOR TO 8/10 ACCIDENT						
Cocaine	DENIES						
Marijuana	DENIES						
Opiates/Heroin	HX ABUSING PERCOCETS/OXYCODONE						
Hallucinogen	DENIES						
Nicotine	↓						
Other	↓						

Gambling Behavior ☒ NO or give details _____

Past Substance Abuse Treatment (*document all previous treatment*)

Inpatient or Outpatient	Where	Reason	Dates of Treatment	Previous Medications	Response to Treatment
IP	CVH	Detox/Rehab	2011		
IP	NOV	↓			
IP	STONINGTON	↓			
OP	WOMSH	ETOH ↓	12/10 to 2011, 8/10, 2005, 2004		

Medical Problems Associated with Drug Use/Withdrawal ☐ NO ☐ Seizures ☐ D T's ☐ Other Blackouts, mild rhabdomyolysis, DT's 10/10 to 11/10

Patient's spiritual orientation

Religion ☐ Protestant ☐ Catholic ☐ Jewish ☒ Other Ø

Able to accept concept of "Higher Power" ☒ YES ☐ NO

Current spiritual activity Ø

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 5:43pm

[redacted] 10/28/2012

ED/ E
Physician, ED

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

FAMILY HISTORY

Psychiatric history ☐ NO or describe Parents-ETOH, Bro-ETOH

SOCIAL & DEVELOPMENTAL HISTORY

Living situation ☐ Homeless ☒ Structured facility ☐ Hotel ☐ Apt ☐ Condo/House ☒ Other [redacted]

With ☐ Alone ☐ Spouse/Sig Other ☐ Family ☒ Other PEERS

Support System (List family members, names and ages, case workers, visiting nurses, etc.)

Pt says he relies on [redacted] staff for help. He has two sons, 20 and 16. Pt reports his family visits him frequently. Pt is divorced.

Recreation Activities

Education (highest level achieved) Associates [redacted]

Veteran ☐ NO ☐ YES

Occupation ☐ Unemployed ☐ Student ☐ Homemaker ☐ Retired ☒ Disabled

☐ Employed / Occupation "use to work with chemicals"

Source of Income Disability

History of abuse:

	Abuser	Abused
Physical Abuse	When	At age
	Victim	By whom
Sexual Abuse	When Ø	At age
	Victim	By whom Ø
Emotional Abuse	When	At age
	Victim	By whom

Has this been reported? ☒ NO ☐ YES To whom

Emotional/Physical effects of Abuse Ø

Sexuality ☒ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Active ☐ Inactive

☐ Single Partner ☐ Multiple Partners ☐ High Risk Behavior

Legal History ☐ NO or give details DUI x3

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 1pm

[redacted] 10/28/2012

ED[redacted] E

Physician, ED

M[redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

SUICIDE RISK ASSESSMENT

1 Risk Factors

a Suicidal behavior ☐ Denies all

(be as specific as possible, must comment if box is checked)

☐ Suicide attempt within the last 24 hrs ☒ History of prior suicide attempt

☒ Aborted suicide attempt ☐ Self injurious behavior

Comment 10/2011 and 10/2010 overdose, hx threatening SI with gun, hx dislocating propane tanks in basement

b Current/past psychiatric or medical disorders ☐ Denies all

☒ Mood disorder ☐ Psychotic disorders ☒ Alcohol/substance abuse ☐ TBI ☐ PTSD

☒ Comorbid Medical illness (acute or current) ☐ ADHD ☐ Personality disorders ☐ conduct disorder

c Key symptoms ☐ Denies all

☐ Anhedonia ☐ Impulsivity ☐ Hopelessness ☒ Helplessness ☒ Anxiety/Panic

☒ Insomnia ☐ Command hallucinations

Comment Related to current medical condition.

d Family History

Attempts and/or completed suicide by family members ☐ Yes ☒ No

Comment

e Precipitants/stressors/interpersonal (real or anticipated) ☐ Denies all

☒ Loss of relationship ☐ Financial stressors ☐ Changes in health status ☒ Ongoing medical illness

☒ Substance use ☐ Family turmoil/chaos ☐ History of physical or sexual abuse ☐ Social isolation

f Change in treatment

☐ Discharge from psychiatric hospital ☐ Change in provider ☐ Change in treatment

Comment Ø

g Access to firearms

☐ Yes ☒ No Comment

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 6pm

[redacted]
Physician, ED

10/28/2012

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

SUICIDE RISK ASSESSMENT (continued)

2. Protective Factors

☐ Ability to cope with stress ☐ Religious beliefs ☒ Responsibility to children/pets ☒ Social support
☐ Frustration tolerence ☐ Positive theraputic relationships ☐ Other _____

3. Suicide Inquiry

a Ideation
Frequency ☐ Never ☒ Rarely ☐ Sometimes ☐ Frequently ☐ Constantly
Intensity ☒ Brief/fleeting ☐ Focused/deliberation ☐ Other _____
Duration ☐ Past 48 hours ☐ Past month ☐ Continuously

b Plan ☐ Yes ☒ No
(If yes must comment)
What denies SI intent/plan
When
Where
How
What has been done to prepare for this

c Behaviors
☐ None ☒ Past attempts ☒ Aborted attempts ☐ Rehearsals ☐ Non-suicidal self-injurious actions

d Intent ☒ Denies intent to harm self ☐ Expectations to carry out the plan ☐ Believes the plan to be lethal

4 Suicide Risk Level

☒ Low ☐ Moderate ☐ High

5. Intervention

☒ MD/APRN notified of risk level

Consider ☐ Inpatient referral ☐ PHP ☐ IOP ☐ Outpatient Referral
☐ 5 minute checks ☐ Constant Visual Observation ☐ Constant Close Observation

☐ Other _____

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 1900

[redacted]
ED[redacted] E
Physician, ED

10/28/2012

M[redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

HOMICIDAL RISK ASSESSMENT

Current ☒ None ☐ Homicidal Ideation ☐ Homicidal Plan ☐ Homicidal Intent
☐ Has access to gun/other method

History of Homicide Attempts ☒ None or describe _____

_____

☒ MD/APRN notified of risk level

If a threat is made to a specific person, note action taken _____

_____

Violence:

Current ☒ No ☐ Yes Describe ☐ Person ☐ Property _____

Past ☒ No ☐ Yes Describe ☐ Person ☐ Property _____

Current risk potential ☒ Low ☐ High Comments Denies HI intent/plan

SIGNATURE/DEGREE/TITLE [redacted]

DATE/TIME 10/28/12 6pm

CN9199

[redacted]

10/28/2012

ED/ E
Physician, ED

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

MENTAL STATUS / REVIEW OF SYMPTOMS

Patient Appearance Pt Eye contact, Trach, laying hospital bed.

Demeanor ☐ Pleasant ☒ Cooperative ☐ Uncooperative ☐ Hostile ☐ Other _____

Motor Activity ☐ Hypoactive ☒ Calm ☐ Restless ☐ Hyperactive ☐ Mannerisms

☐ Tics ☐ Tremors ☐ Dyskinesia ☐ Other _____

Attitude ☐ Apathetic ☒ Cooperative ☐ Friendly ☐ Guarded ☐ Suspicious ☐ Uncooperative

☐ Belligerent ☐ Threatening ☐ Hostile ☐ Other _____

Speech ☒ Normal Latency ☒ Normal Volume ☒ Normal Fluency ☐ Mute ☐ Delayed

☐ Soft ☐ Impoverished ☐ Slurred ☐ Incoherent ☐ Loud ☐ Pressured ☐ Excessive

☐ Other _____

Mood Scared, Sad

Affect ☐ Apathetic ☐ Interested ☐ Bright ☐ Anxious ☒ Sad ☐ Angry ☐ Other _____

Reactivity ☒ Normal ☐ Decreased ☐ Increased

Range ☒ Normal ☐ Decreased ☐ Increased

Appropriateness to mood/situation ☒ Yes ☐ No Describe if No _____

Perceptions

Hallucinations ☐ No ☒ Yes If Yes mark as indicated

☐ Auditory ☒ Visual ☐ Olfactory ☐ Gustatory ☐ Tactile illusions ☐ Distortions

Thought Pattern ☐ Slowed ☒ Normal ☐ Coherent ☐ Circumstantial ☐ Blocked

☐ Racing ☐ Loose Association ☐ Derailing ☐ Word Salad ☐ Incoherent

☐ Flight of Ideas ☐ Depersonalization ☐ Derealization

☐ Command (describe content) _____

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 6:11pm

[redacted] 10/28/2012

ED/ E
Physician, ED

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

MENTAL STATUS / REVIEW OF SYMPTOMS (continued)

Insight ☐ Intact ☒ Impaired Describe if impaired 2° depression

Judgment ☐ Intact ☒ Impaired Describe if impaired 2° depression

Thought content

Delusions ☒ No ☐ Yes If yes, mark as indicated

☐ Grandiose ☐ Persecutory ☐ Of Control ☐ Somatic ☐ Bizarre ☐ Ideas of Reference

☐ Thought insertion ☐ Thought broadcasting ☐ Obsessions ☐ Compulsions

☐ Phobia ☐ Paranoia

Sensorium and Cognitions:

Level of Consciousness ☒ Alert ☐ Fluctuating ☐ Hyperalert ☐ Drowsy ☐ Lethargic

Orientation: ☒ Date ✓ ☒ Person ✓ ☒ Place ✓

Disorientation: ☐

Recent Memory ☒ Intact ☐ Impaired Remote Memory ☒ Intact ☐ Impaired

Attention ☒ Intact ☐ Impaired Concentration ☒ Intact ☐ Impaired

Cognitive Status:

Evidence of Cognitive Deficits: ☐ Yes ☒ No

If yes, or if Older than 55 complete FOLSTEIN MINI MENTAL STATE ON PAGES 13 & 14.

Additional Symptom Review:

Sleep ☐ No Change or Describe ↓

Appetite ☐ No Change or Describe ↓

Energy ☐ No Change or Describe ↓

Manic Symptoms ☒ No Change or Describe

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 6:12pm

[redacted] 10/28/2012

ED/ E
Physician, ED

M [redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

CLINICAL SUMMARY / IMPRESSION Pt is 55y.o male BIBA 2° ↑blood pressure and ↑in confusion/VH.

Patient ☒ is not ☐ is at acute risk to self
Patient ☒ is not ☐ is at acute risk to others
Patient ☒ is not ☐ is in need of psychiatric hospitalization

3per Dr. [redacted]

ICD-9 Code

780.09

799.9

DSM IV MULTI-AXIAL DIAGNOSIS

Axis I Delirium NOS
DDX
Axis II Deferred
DDX
Axis III CM, Trach, hypokalemia, HTN, gastritis, hyperlipidemia, hypo-adrenal ESRF
Axis IV CM, motorcycle accident 8/2012 causing inability move legs/arms
Axis V Current M-GAF 40 (Modified Global Assessment Functioning) Highest M-GAF in past year unknown (Modified Global Assessment Functioning)

PLAN

Is patient motivated for treatment? ☒ Yes ☐ No
Disposition D/C back to [redacted]
Treatment Recommendation Stop Ambien, Start Lunesta 2mg

Referral to protective agency ☐ Yes ☒ No ☐ DCF ☐ DSS
If yes, describe _____
Patient's readiness for education is impacted by (mark all that apply)
☒ No impact ☐ Patient's and family's beliefs and values ☐ Literacy ☐ Language
☐ Motivation ☐ Physical State ☐ Cognitive Limitations ☐ Finances
☐ Actions to be taken for positive findings _____

PHYSICIAN CASE REVIEW (check appropriate box, at least one box must be checked)

☐ I have evaluated this patient including risk assessment and concur with the plan for the patient
MD/APRN SIGNATURE _____ Date _____

And/or

☒ I have reviewed this evaluation with [redacted] including risk assessment and he/she is in agreement with findings and plan
MD/APRN

SIGNATURE/DEGREE/TITLE [redacted] DATE/TIME 10/28/12 6:18pm

[redacted]
ED/ E
Physician, ED

10/28/2012

[redacted]

SINGLE PATIENT ASSESSMENT OF DATA
BEHAVIORAL HEALTH OF WATERBURY HOSPITAL

PHYSICIAN COMPONENT

SUMMARY OF INTERVIEW The case is reviewed c̄ clinician and pt is seen
Brief Hx: pt is a 55 year old Caucasian male sent from [redacted]
Rehab facility. He reportedly had an hallucinatory experience
of seeing his friend fall of the chair sitting next to
him on visit. He was taking a nap, just before that.
He has been having these hallucinatory experience for the
past week. He was expecting visit by his former colleague
pt has been in a Motorcycle Accident, in August
this year. He lost movements in his upper arms, and
legs. He is in Rehab, and has regained some movement
in upper arm and legs. He is bed ridden. He is
on Cymbalta and Ambien. Ambien started couple of
weeks. He has been having hallucinatory experiences, when
he wakes up, but realizing it is not real when
fully awake. He is on [illegible]
pt has Hx Alcohol Abuse, opioid use
before this incident. He also had impulse control

RECOMMENDATIONS AND PLAN disorder. pt has no past Hx of Major Depression
Medical Hx of paraplegia, ESRD on
dialysis, HTN, Hyperlipidemia, Vit B12 deficiency
MSE: pt appears stated age, lying in bed on
Plan: pt is assessed — his back with Tracheostomy pipe through neck. He
to be Safe in [illegible] — is alert ox3, calm, co-operative, [illegible]
on bed c̄ Side rails — He is aware of his hallucinatory experience
which he has been experiencing for the last
Recommend — week, no [illegible] Hallucinatory Experience.
D/c Ambien as — the client [illegible] depressed, denies S/H ideation.
it is known to — There is no evidence of thought disorder.
induce delirium — A/p Delirium r/o.
Experience — Rx Metabolic or Med induced delirium.
Try Lunesta 2 mg — paraplegia, HTN, ESRD, Hyperlipidemia
hs for sleep.

I have reviewed the preceeding Clinician Assessment including Risk Management and agree with contents

[redacted] MD / APRN DATE/TIME 10/28/12 6:15 pm

CN9199

[redacted]

ED Note-Physician

Result date: 28 October 2012 18:22 EDT
Result status: Auth (Verified)

Addendum *ED

[redacted]

Attachments: None

Medical Decision Making

Notes: seen by BH; recomend stopping Ambient; starting lunesta 2mg. Seen and treated by MD, Maria O'rouke and medically cleared; stable for dsicharge.

[redacted]

Psychiatrist Note Transcribed

Single Patient Assessment of Data
Behavioral Health of Waterbury Hospital
Physician Component

Summary of Interview: The case was reviewed with clinician and pt seen.
Briefly the pt is a 55 yo Caucasian male sent from [redacted]. He reported had a hallucinatory experience of seeing his friends [illegible] seeing him on a visit. He was taking a nap just before that. He has been having this hallucinatory experience for the past week. He was expecting visits by his friends today.

Pt has been in a motorcycle accident in August this year. He lost movement in his upper arms and legs. He is in Rehab and has regained some movement in arms and legs. He is bed ridden. He is on Cymbalta and Ambien. Ambien started couple of weeks. He has been having hallucinatory experiences when he wakes up but realizes its not real when fully awake. He has a tracheostomy.

Pt has history of alcohol abuse, opiate use before this incident. He [illegible] impulse control disorder. Pt has been in treatment for Major Depressive Disorder. Medical history of paraplegia., ESRD [end stage renal disease] on dialysis, HTN [hypertension], hypokalemia, Vit[amin] B12 deficiency, [illegible]. Pt appears stated age, lying in bed on his back with tracheostomy attached to vent[ilator]. He is alert and oriented x 3. Calm, cooperative, articulate. He is aware of his hallucinatory experiences. He denies feeling depressed, denies S[uicidal]/H[omicidal] ideation. THere is not evidence of a thought disorder.

A/P: Delerium NOS
R/o metabolic or medical causes of delirium
[illegible] HTN, ESRD, hyperlipidemia

Plan: Pt is assessed to be safe [illegible]
Recommend: D/C Ambien as it is known to cause delirious experiences. Try Lunesta 2 mg HS for sleep.